Executive Summary

In 1996, the Washington State Legislature, with the enactment of Chapter 43.06A RCW, created the Office of the Family and Children's Ombudsman. The Legislature charged the Ombudsman with investigating complaints involving children and families receiving child protection and child welfare services, or any child reported to be at risk of abuse, neglect or other harm. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families.

The Ombudsman's Role:

- Investigate and respond to complaints
- Recommend system-wide improvements
- Educate citizens about the child welfare process
- Act on behalf of children and families

The Role of the Ombudsman

The Ombudsman operates under the Office of the Governor, independent of the Department of Social and Health Services (DSHS). Acting as a fact finder, the Ombudsman provides families and citizens an avenue through which they can obtain an independent and impartial review of the decisions made by DSHS and other state agencies.

The Ombudsman performs its duties by focusing its resources—five-and-a-half full-time staff and a biennial budget of nearly one million dollars—on complaint investigations, complaint intervention and resolution, and system investigations and improvements.

Inquiries and Complaints

A fundamental aspect of the Ombudsman's work is to respond to the needs of citizens by listening to their concerns, educating them about the child welfare process and referring them to appropriate resources to assist them with a particular issue. To respond effectively to citizens' questions and concerns, the Ombudsman first determines if their concern falls within the scope of the Ombudsman to investigate, or if there is another resource available to better assist them.

Between September 1, 2003 and August 31, 2005, the Ombudsman received over 3,000 inquiries from families and citizens who needed information. During this same two-year period, the Ombudsman received over 900 complaints.

Most of the complaints filed with the Ombudsman were filed by parents and other family members. The top two issues citizens brought to the Ombudsman were 1) complaints about child safety, expressing concerns about the inadequate response by DSHS to reported maltreatment of children, and 2) complaints expressing concerns about family separations and reunification. In addition, a significant number of complaints involved the health, well-being and permanency of dependent children.

Complaint Investigation and Ombudsman in Action

The Ombudsman spends more time investigating and evaluating complaints than on any other activity. Impartial investigation and analysis enable the office to respond effectively when action is necessary to facilitate resolution of a concern or induce corrective action by the agency.

Between September 1, 2003 and August 31, 2004, the Ombudsman completed 425 complaint investigations and between September 1, 2004 and August 31, 2005, the Ombudsman completed 427 complaint investigations. For both reporting years, the majority of completed investigations were standard, non-emergent investigations (84%). Approximately one out of six complaints, however, met the Ombudsman criteria for an emergent complaint. These most often involved complaints about child safety or well-being.

In previous years, the annual report included three main categories of Ombudsman actions: inducing corrective action, facilitating resolution, and preventing future mistakes. This year the Ombudsman captures a previously unreported category: poor practice. These cases involve decisions by agency personnel that, although not violations of law, policy, or procedure, do not reflect best practice. In these cases, the Ombudsman intervened if the action complained of was current, or brought to the agency's attention the failure to achieve best practice if the complaint involved past action. The actions listed in this new category made up 33% of the total actions reported by the Ombudsman.

Review of Fatalities

The Ombudsman receives notice from DSHS/DCFS on every fatality known to DCFS. This information sharing is a critical step in the Ombudsman's review of cases in which child abuse or neglect is identified as a factor in the death of a child.

In the past two years, the Ombudsman conducted two investigations into high profile fatalities. Justice and Raiden Robinson died with a CPS referral still open after 9 months. Sirita Sotelo died two months after her dependency was closed. Based on these two investigations, the Ombudsman made a series of recommendations for DSHS including:

- Improving procedures for case reviews by CPS supervisors;
- Implementing caseload standards for CPS workers and supervisors;
- Modifying the statutory provisions governing CPS investigations and interventions;
- Requiring CPS to attempt to obtain mental health evaluations of a parent when mental health issues contribute to the alleged child abuse or neglect;
- Strengthening case supervision following a child's return to a parent's care;
- Assuring that appropriate services for successful reunification are provided; and
- Improving assessment of other adult caregivers in parent's home.

In view of the valuable information gathered from examining the Robinson and Sotelo child fatalities, the Ombudsman compiled and analyzed data on unexpected deaths of 87 children who died in 2004. These children had received services from DSHS Children's Administration within one year of their death, or had been in the care of the agency within this timeframe.

This analysis led to the development of several practice and systemic recommendations within this annual report, which we believe will substantially improve the child protection system. Among these, the Ombudsman recommends reinstating a coordinated statewide child fatality review process so that both the Department of Health and the Department of Social and Health Services Children's Administration can bring their joint expertise to the table. This will put back into place a solid framework to ensure that all sudden and unexpected deaths of children are reviewed and that such reviews reflect a multidisciplinary approach.

A proper review depends on getting accurate and reliable data. For that reason, among our recommendations you will find a suggestion that counties be audited to ensure that unexpected deaths of young children are being investigated in accordance with protocols that have been established pursuant to Washington's SIDS law, Chapter 43.103 RCW.

The Ombudsman believes it is critical there be a system in place to monitor implementation of recommendations that arise from child fatality reviews. Unless this is put into place, the value of child fatality reviews is undermined.

Our review of these 87 deaths confirmed what we already knew—that child fatalities represent the greatest failure of the child protection system, but also the most meaningful opportunity for reform. For the study of a child's death to result in improved practice, it must be based on complete, accurate, and impartial data; and a multidisciplinary group of professionals must evaluate these recommendations to prioritize them, and determine how they should be implemented. Without a concrete system for considering and implementing such changes based on the findings of these investigations, the reviews are an exercise in futility.

Foster Parent Retaliation

In 2004, the Legislature gave foster parents the clear right to file a complaint with the Ombudsman if they believed they had been retaliated against for engaging in a protected activity, such as advocating for services on behalf of the foster child. In response to the 2004 legislation, the Ombudsman developed an analytical framework for determining whether retaliation had occurred. Retaliation complaints are complex because of vastly contradictory interpretations of events. As a result, making a determination of whether or not retaliation occurred can be a difficult, time consuming process. But if illegal retaliation occurred, then the Ombudsman will intervene.

In addition to the response to the retaliation legislation, the Ombudsman has conducted a series of meetings with foster parents, in organized groups and in other settings, to hear the concerns of foster parents regarding our current foster care system. Several of these concerns are listed in this report.

Issues and Recommendations

After complaint investigations, the Ombudsman spends the most time on identifying and investigating system-wide problems. The Ombudsman has identified and investigated three systemic issues that are the subject of findings and recommendations in this report:

1. Reduce caseloads of caseworkers and supervisors;
2. Provide caregivers with a greater and more consistent opportunity to be heard; and
3. Provide relatives who have an established relationship with a child ongoing contact after the child has been placed out of home pursuant to a dependency action.

In addition, the Ombudsman has identified four areas of concern that the Ombudsman intends to review and investigate in the coming year. The systemic recommendations are to:

1. Inadequate recruitment, licensure, and retention of foster homes;
2. Inadequate screening of individuals who provide care to dependent children and youth under the supervision of the state as well as non-dependent children in licensed daycare;

3. Failure of DCFS to encourage the maximum parent and child and sibling contact possible, consistent with existing law; and
4. Removal of children from long-term care pre-adoptive placements.

Response to the Ombudsman's Previous Systemic Recommendations

This section details the responses of the Children's Administration and the Legislature to systemic recommendations made by the Ombudsman in previous reports, including the 1999, 2000, 2003 Annual Reports, and the Justice and Raiden Robinson Fatalities Review Report. These responses include a number of policy changes on the part of the Children's Administration. These responses also include two bills passed by the Legislature that address recommendations made in part by the Ombudsman regarding the need for greater protection of adolescents and intervention in cases of chronic neglect.

Ombudsman Activities

In addition to investigating complaints and investigating systemic problems, the Ombudsman is also charged with promoting public awareness and understanding of family and children services. The Ombudsman accomplishes this task by actively participating on committees established to critically examine child protection/welfare issues, presenting at conferences, reviewing and analyzing proposed legislation, testifying before the Legislature, and conducting site visits of state-licensed facilities. Included in this section is a list of such activities the Ombudsman has completed in the past two years.

Terms and Acronyms:

Dependent Child .....A child for whom the state is acting as the legal parent.
CA .....Children's Administration
CPS.....Child Protective Services
CPT .....Child Protection Team
CWS .....Child Welfare Services
DSHS .....Department of Social and Health Services
DCFS.....Division of Children and Family Services
FRS.....Family Reconciliation Services